| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0000 | A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).<br><br>Survey Date: 02/28/11 and 03/01/11<br><br>Facility Number: 000235<br>Provider Number: 155343<br>AIM Number: 100267740<br><br>Surveyor: Richard D. Schade, Life Safety Code Specialist<br><br>At this Life Safety Code survey, Life Care Center of LaGrange was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. | K0000 | The provider wishes this plan of correction be considered our allegation of compliance.The following response and corrective action stated within this 2567 plan of correction should not be considered as an admission of guilt or wrong doing on the part of Life Care Center of LaGrange. The plan of correction is prepared and executed solely because it is required by the provision of Federal and State laws. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 100 and had a census of 74 at the time of this survey.<br><br>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 03/07/11.<br><br>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following: | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0018 SS=E | Based on observation and interview, the facility failed to ensure 1 of more than 150 corridor doors would latch into the door frame or were provided with a device that exerts at least 5 pounds of pressure to keep the door tightly closed. This deficient practice could effect occupants in the south wing, 200 hall smoke compartment including staff, visitors and residents.<br><br>Findings include:<br><br>Based on observation on 03/01/11 at 10:45 a.m. with the maintenance supervisor, the corridor door to resident room 205 was not equipped with a latch which latched into the door frame, or a device to provide at least five pounds of pressure to keep the door closed. The maintenance supervisor acknowledged at the time of observation, the door did not remain latched when pressure was applied. | K0018 | K 0018<br>Corrective action accomplished for residents affected by the alleged deficient practice: On 3/1/11, the maintenance director fixed the door latch on room 205.<br>How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director or designee will conduct a weekly audit to ensure all doors latch properly.<br>What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist to ensure that all doors latch properly.<br>How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits. | 03/31/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-19(b) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0143 SS=E | Based on observation and interview, the facility failed to ensure 1 of 1 liquid oxygen storage areas was provided with signage indicating oxygen transferring is occurring. This deficient practice could affect residents, staff and visitors in and near the oxygen storage and transfilling room.<br><br>Findings include:<br><br>Based on observation with the maintenance supervisor during a tour of the facility at 10:25 a.m. on 03/01/11, the facility's oxygen storage and transfilling room located across from the kitchen was not provided with a sign indicating transferring of oxygen was occurring. Based on interview at the time of observation, the maintenance supervisor acknowledged the transferring of oxygen does occur in the oxygen storage and transfilling room and no sign indicating the transferring of oxygen was occurring in the | K0143 | K 0143<br>Corrective action accomplished for residents affected by the alleged deficient practice: On 3/25/11, the maintenance director ordered a sign which states, "OXYGEN TRANSFER STATION OPEN/IN USE."<br>How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director or designee will monitor weekly to ensure the oxygen room has proper signage.<br>What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist the monitoring of proper oxygen room signage.<br>How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits. | 03/31/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | facility's oxygen storage and transfilling room was provided.<br><br>3.1-19(b) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K0144 SS=F | Based on observation, record review and interview; the facility failed to ensure 1 of 1 emergency generators was equipped with remote manual stops. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break-glass station located elsewhere on the premises where the prime mover is located outside the building. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, | K0144 | K 0144<br>Corrective action accomplished for residents affected by the alleged deficient practice: On 3/11/11, the maintenance director contacted H & G Services to install an emergency shut switch on the emergency generator.<br>How the facility will identify other residents potentially affected by the same deficient practice: The maintenance director or designee will conduct an audit on the non load test and monthly load test weekly and will document in the preventative maintenance logs.<br>What measures were put into place or systemic changes made to ensure that the alleged deficient practice does not recur: The maintenance director will add to his facility rounds checklist to ensure the generator is functioning per regulation.<br>How corrective actions will be monitored to ensure the alleged deficient practice will not recur: The maintenance director or designee will follow the above audits for three months and provide the Executive Director with the results of those audits monthly. The Executive Director will present data from the audits at the monthly QA/QI meetings. Utilizing a threshold of 100%, at the discretion of the QI committee, audits will then be adapted to accommodate the need to increase/decrease the number of audits and frequency of audits. | 03/31/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | staff and visitors in the event of an emergency.<br><br>Findings include:<br><br>Based on review of the Generator Maintenance records on 02/28/11 at 3:40 p.m. with the maintenance supervisor, there was no documentation available which indicated the amount of horsepower the generator provided. Based on observation of generator equipment on 03/01/11 at 10:45 a.m. during a tour of the facility with the maintenance supervisor, no evidence of a remote shut off device was found for the generator, furthermore, the maintenance supervisor indicated he was not sure if the generator was 100 horsepower or more and it was installed prior to 2003. The maintenance supervisor thought there was a remote shut off device for the generator and tried to test a switch, but it failed to stop the generator from running. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155343 | A. BUILDING _____ B. WING _____ | 03/01/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LIFE CARE CENTER OF LAGRANGE | 0770 N 075 E LAGRANGE, IN46761 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | 3.1-19(b) | | | |